State: *Arkansas* ***Filing Company:*** *Colonial Penn Life Insurance Company*
TOI/Sub-TOI: *L07I Individual Life - Whole/L07I.111 Single Premium - Single Life*
Product Name: *Individual Life Insurance*
Project Name/Number: */*

Filing at a Glance

Company:	Colonial Penn Life Insurance Company
Product Name:	Individual Life Insurance
State:	Arkansas
TOI:	L07I Individual Life - Whole
Sub-TOI:	L07I.111 Single Premium - Single Life
Filing Type:	Form
Date Submitted:	09/20/2012
SERFF Tr Num:	BNLC-128694484
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	12-82-049(F)(REV)
Implementation Date Requested:	01/01/2013
Author(s):	Wilbur Henderson
Reviewer(s):	Linda Bird (primary)
Disposition Date:	09/26/2012
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Colonial Penn Life Insurance Company*
TOI/Sub-TOI: *L07I Individual Life - Whole/L07I.111 Single Premium - Single Life*
Product Name: *Individual Life Insurance*
Project Name/Number: */*

General Information

Project Name:
Project Number:
Requested Filing Mode: Informational
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Wilbur Henderson

Status of Filing in Domicile: Authorized
Date Approved in Domicile: 09/12/2012
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 09/26/2012
State Status Changed: 09/26/2012
Created By: Wilbur Henderson
Corresponding Filing Tracking Number: 12-82-049(F)(REV)

Filing Description:
RE: Individual Life Insurance

12-82-049(F)(REV) Application
12-82-050(F)(REV) Application
12-82-055(REV) Application
12-82-056(REV) Application
12-82-057(REV) Application
12-82-058(REV) Application

NAIC# 233-62065
FEIN# 23-1628836

Dear Mr./MS:

Attached for your review and approval are copies of the above captioned forms. These forms are new and will replace corresponding forms currently on file with your Department.

These forms were previously approved by your Department. The only change to these new forms is the mandated MIB,Inc language change in the authorization section at the end of the second paragraph, which reads, " I authorize the Company, or its reinsurer, to make a brief report of my personal health information to MIB". This change is effective 1/1/13. No other changes have been made to the applications. Coverage will continue to be marketed on a direct response simplified issue basis.

To assist with submission, below are the previously approved applications with approval information:

Application Approval Date SERFF Trk # State Trk #

12-82-049(F) 8/26/10(all) BNLC-126676280 (all) 46598 (all)
12-82-050(F)
12-82-055
12-82-056
12-82-057
12-82-058

State: *Arkansas* **Filing Company:** *Colonial Penn Life Insurance Company*
TOI/Sub-TOI: *L07I Individual Life - Whole/L07I.111 Single Premium - Single Life*
Product Name: *Individual Life Insurance*
Project Name/Number: */*

We have also included an Officer's Certification acknowledging no other changes to these forms. These new forms upon approval effective 1/1/13 will continue to be with previously approved policy forms currently on file with your Department. Should you need additional information, do not hesitate to contact me.

Wilbur Henderson Jr

Company and Contact

Filing Contact Information

Wilbur Henderson Jr., Contract Analyst
399 Market Street
Philadelphia, PA 19181

whenderson@colpenn.com
215-928-6085 [Phone]
215-928-6431 [FAX]

Filing Company Information

Colonial Penn Life Insurance Company
399 Market Street
Philadelphia, PA 19181
(215) 928-8688 ext. [Phone]

CoCode: 62065
Group Code: 233
Group Name:
FEIN Number: 23-1628836

State of Domicile: Pennsylvania
Company Type: Life/Health
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$300.00
Retaliatory?	No
Fee Explanation:	$50.00 per form (6)
Per Company:	No

Company	Amount	Date Processed	Transaction #
Colonial Penn Life Insurance Company	$300.00	09/20/2012	62880579

SERFF Tracking #:	*BNLC-128694484*	***State Tracking #:***		***Company Tracking #:***	*12-82-049(F)(REV)*

State:	*Arkansas*	***Filing Company:***	*Colonial Penn Life Insurance Company*
TOI/Sub-TOI:	*L07I Individual Life - Whole/L07I.111 Single Premium - Single Life*		
Product Name:	*Individual Life Insurance*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/26/2012	09/26/2012

SERFF Tracking #:	*BNLC-128694484*	***State Tracking #:***		***Company Tracking #:***	*12-82-049(F)(REV)*

State:	*Arkansas*	***Filing Company:***	*Colonial Penn Life Insurance Company*
TOI/Sub-TOI:	*L07I Individual Life - Whole/L07I.111 Single Premium - Single Life*		
Product Name:	*Individual Life Insurance*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 09/26/2012
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Officers Certification		Yes
Supporting Document	Copy of Approval		Yes
Form	Application		Yes
Form	Application		Yes
Form	Application		Yes
Form	Application		Yes
Form	Application		Yes
Form	Application		Yes

SERFF Tracking #:	*BNLC-128694484*	***State Tracking #:***		***Company Tracking #:***	*12-82-049(F)(REV)*

State:	*Arkansas*	***Filing Company:***	*Colonial Penn Life Insurance Company*
TOI/Sub-TOI:	*L07I Individual Life - Whole/L07I.111 Single Premium - Single Life*		
Product Name:	*Individual Life Insurance*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: 12-82-049(F)(REV)

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		12-82-049(F)(REV)	AEF	Application	Initial:	57.200	12-82-049(F)(REV).pdf
2		12-82-050(F)(REV)	AEF	Application	Initial:	57.200	12-82-050(F).pdf
3		12-82-055(REV)	AEF	Application	Initial:	57.200	CPL_EM055.pdf
4		12-82-056(REV)	AEF	Application	Initial:	57.200	CPL_EM056.pdf
5		12-82-057(REV)	AEF	Application	Initial:	57.200	CPL_EM057 (2).pdf
6		12-82-058(REV)	AEF	Application	Initial:	57.200	CPL_EM058.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

COLONIAL PENN LIFE INSURANCE COMPANY, Philadelphia, PA 19181
SIMPLIFIED ISSUE APPLICATION for

Proposed Insured [John Doe]
Address [123 Main St.]
City [Anytown] **ST** [OH] **ZIP** [00000-0000]

Area Code/Phone # - Day [000-000-0000]
Area Code/Phone # - Evening [000-000-0000]
E-Mail Address [xxxxxxxxxxxxxxxxxxxxx]
Age [x] **Date of Birth** [00/00/0000] **Sex** [x]

Please check ✓ your desired insurance protection and payment option:

Amount of Life Insurance: ☐ $0,000 ☐ $0,000 ☐ $00,000 ☐ $00,000 ☐ $00,000 ☐ $00,000

Initial Premium Enclosed: ☐ Monthly ☐ Annual $_____

Check here ☐ **for Monthly Automatic Bank Deduction** *and sign below.*
Your initial premium check will give us all the information we need. I authorize Colonial Penn Life Insurance Company to charge my insurance premiums, including past due amounts, to my bank account on or after the day I have selected below. I understand that if a draft on my bank account fails due to insufficient available funds, Colonial Penn will submit the draft again within a week. This authorization is to remain in effect until I inform Colonial Penn otherwise and allow reasonable time to cancel this payment arrangement.

Payor's Signature X _____ **Premium Deduction Date** _____
(As Name Appears on Bank Account) (3rd to 28th Day of the Month)

1. Statement of Health — Your answers to the questions below help determine your eligibility for this coverage. Answer each of the questions "Yes" or "No." If "Yes" circle the condition(s) which apply. Additional information may be necessary.

A. Are you currently: (1) using assistance from another person to perform your daily activities such as dressing, eating or walking; (2) using a walker, wheelchair or motorized mobility device; (3) using supplemental oxygen; (4) confined to a hospital, assisted care or nursing facility, or correctional institution? ☐ **Yes** ☐ **No**

B. Have you been advised to have in-patient surgery which has not yet been performed? ☐ **Yes** ☐ **No**

C. In the past three years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis; (2) chronic liver disease (including chronic hepatitis), cirrhosis of the liver; (3) chronic kidney disease (not including kidney stones); (4) heart attack (myocardial infarction), cardiac arrhythmia, or congestive heart failure; (5) thrombosis or embolism (blood clots)? ☐ **Yes** ☐ **No**

D. In the past five years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) stroke, transient ischemic attack (TIA), or heart or blood vessel surgery; (2) dementia, Alzheimer's disease, or ALS (amyotrophic lateral sclerosis); (3) diabetes; (4) cancer (not including basal cell skin cancer); (5) AIDS (Acquired Immunodeficiency Syndrome), infection with HIV (Human Immunodeficiency Virus), or other immune system disorder; (6) mental or nervous system disorder for which inpatient treatment or confinement in an institution was recommended or completed; (7) alcohol or drug abuse, or has treatment been recommended? ☐ **Yes** ☐ **No**

E. Physician _____
Please Print Name Address Area Code and Phone No.

2. Beneficiary Designation (will be divided equally unless noted otherwise)

A. _____ _____ _____ B. _____ _____ _____
Beneficiary Name (Please Print) Relationship to You % Share Beneficiary Name (Please Print) Relationship to You % Share

3. Is this insurance intended to replace or change any existing life insurance or annuity plan? ☐ **Yes** ☐ **No**

_____
Name of Insurance Company Plan of Insurance Amount of Insurance

I have read the questions and my answers are true to the best of my knowledge and belief. I understand that this application shall form a part of any policy issued and that, within the contestable period, a false statement or answer can be used to contest the policy as of its effective date or to deny a claim. **I understand and agree that no life insurance is in effect as a result of this application unless this application is approved by the Company, a policy is issued during my lifetime and my continued insurability, according to medical information provided in this application and the premium has been paid.** The policy will be effective on the Policy Date shown on the Policy Schedule.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or any other organization, institution or person, that has any records or knowledge of me or my health, to give to Colonial Penn Life Insurance Company and its underwriters or reinsurers any such information. I understand such information will be used to determine my eligibility for this insurance. A reproduction of this authorization shall be as valid as the original. The authorization will be valid for a period of 24 months from the date signed. I understand that upon request, I or an authorized representative have a right to receive a copy of this authorization. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. I have received and read the Notice to Applicant.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Proposed Insured X _____ **Date:** _____
(Your Legal Signature/Do Not Print)

COLONIAL PENN LIFE INSURANCE COMPANY, Philadelphia, PA 19181
APPLICATION for

Proposed Insured [John Doe]
Address [123 Main St.]
City [Anytown] **ST** [OH] **ZIP** [00000-0000]

Area Code/Phone # - Day [000-000-0000]
Area Code/Phone # - Evening [000-000-0000]
E-Mail Address [xxxxxxxxxxxxxxxxxxxxx]
Age [x] **Date of Birth** [00/00/0000] **Sex** [x]

Please check ✓ your desired insurance protection and payment option:

Amount of Life Insurance: ☐ $0,000 ☐ $0,000 ☐ $00,000 ☐ $00,000 ☐ $00,000 ☐ $00,000

Amount of Accidental Death Protection: ☐ $0,000 ☐ $0,000 ☐ $00,000 ☐ $00,000 ☐ $00,000 ☐ $00,000

Initial Premium Enclosed: ☐ Monthly ☐ Annual Life $ _____ + Accidental Death $_____ = Total $_____

Check here ☐ **for Monthly Automatic Bank Deduction** *and sign below.*
Your initial premium check will give us all the information we need. I authorize Colonial Penn Life Insurance Company to charge my insurance premiums, including past due amounts, to my bank account on or after the day I have selected below. I understand that if a draft on my bank account fails due to insufficient available funds, Colonial Penn will submit the draft again within a week. This authorization is to remain in effect until I inform Colonial Penn otherwise and allow reasonable time to cancel this payment arrangement.

Payor's Signature X _____ **Premium Deduction Date** _____
(As Name Appears on Bank Account) (3rd to 28th Day of the Month)

1. Statement of Health — Answer each of the following questions "Yes" or "No." If "Yes," (circle) the condition(s) which apply.

A. Are you currently: (1) using assistance from another person to perform your daily activities such as dressing, eating or walking; (2) using a walker, wheelchair or motorized mobility device; (3) using supplemental oxygen; (4) confined to a hospital, assisted care or nursing facility, or correctional institution? ☐ **Yes** ☐ **No**

B. Have you been advised to have in-patient surgery which has not yet been performed? ☐ **Yes** ☐ **No**

C. In the past three years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis; (2) chronic liver disease (including chronic hepatitis), cirrhosis of the liver; (3) chronic kidney disease (not including kidney stones); (4) heart attack (myocardial infarction), cardiac arrhythmia, or congestive heart failure; (5) thrombosis or embolism (blood clots)? ☐ **Yes** ☐ **No**

D. In the past five years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) stroke, transient ischemic attack (TIA), or heart or blood vessel surgery; (2) dementia, Alzheimer's disease, or ALS (amyotrophic lateral sclerosis); (3) diabetes; (4) cancer (not including basal cell skin cancer); (5) AIDS (Acquired Immunodeficiency Syndrome), infection with HIV (Human Immunodeficiency Virus), or other immune system disorder; (6) mental or nervous system disorder for which inpatient treatment or confinement in an institution was recommended or completed; (7) alcohol or drug abuse, or has treatment been recommended? ☐ **Yes** ☐ **No**

E. Physician _____
Please Print Name Address Area Code and Phone No.

2. Beneficiary Designation (will be divided equally unless noted otherwise)

A. _____ _____ _____ B. _____ _____ _____
Beneficiary Name (Please Print) Relationship to You % Share Beneficiary Name (Please Print) Relationship to You % Share

3. Is this insurance intended to replace or change any existing life insurance or annuity plan? ☐ **Yes** ☐ **No**

_____
Name of Insurance Company Plan of Insurance Amount of Insurance

I have read the questions and my answers are true to the best of my knowledge and belief. I understand that this application shall form a part of any policy issued and that, within the contestable period, a false statement or answer can be used to contest the policy as of its effective date or to deny a claim. **I understand and agree that no life insurance is in effect as a result of this application unless this application is approved by the Company and a policy is issued during my lifetime and my continued insurability, according to medical information provided in this application. In addition, no life insurance or, if elected, additional accidental death protection, is in effect unless the appropriate premium has been paid.** The life insurance benefit will be effective on the Policy Date shown on the Policy Schedule. If I elected additional accidental death protection, the accidental death benefit will be effective on the Rider Effective Date shown on the rider attached to the policy.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or any other organization, institution or person, that has any records or knowledge of me or my health, to give to Colonial Penn Life Insurance Company and its underwriters or reinsurers any such information. I understand such information will be used to determine my eligibility for this insurance. A reproduction of this authorization shall be as valid as the original. The authorization will be valid for a period of 24 months from the date signed. I understand that upon request, I or an authorized representative have a right to receive a copy of this authorization. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. I have received and read the Notice to Applicant.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signature of Proposed Insured X _____ **Date:** _____
(Your Legal Signature/Do Not Print)

Instructions:

1. Please review and complete this form. If you make changes, please make them on both copies and initial your changes. Be sure to sign and date both copies and return one copy to us. Attach the other copy to your Policy.
2. Make a check or money order payable to Colonial Penn Life for the amount shown on your premium notice. If you are paying by credit card, we will automatically charge your premium to your credit card.

Questions? Call us Toll-Free ############## for Assistance

APPLICATION For ##################
Colonial Penn Life Insurance Company, Philadelphia, PA 19181

Source Code: ##########
##########
########

Proposed Insured ############################## ## ## ##	**E-Mail Address:** !! **Date of Birth:** ######## **Age:** ## **Sex:** ######
Area Code/Phone: ############	**Area Code/Phone:**
Amount of Life Insurance: ########## **I wish to pay:** ############	**Amount of premium payment:** #########

1. Statement of Health -- Answer each of the following questions "Yes" or "No." If "Yes" *CIRCLE* the condition(s) which apply.

A. Are you currently: (1) using assistance from another person to perform your daily activities such as dressing, eating or walking; (2) using a walker, wheelchair or motorized mobility device; (3) using supplemental oxygen; (4) confined to a hospital, assisted care or nursing facility, or correctional institution? ( ) Yes (X) No

B. Have you been advised to have in-patient surgery which has not yet been performed? ( ) Yes (X) No

C. In the past three years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis; (2) chronic liver disease (including chronic hepatitis), cirrhosis of the liver; (3) chronic kidney disease (not including kidney stones); (4) heart attack (myocardial infarction), cardiac arrhythmia, or congestive heart failure; (5) thrombosis or embolism (blood clots)? ( ) Yes (X) No

D. In the past five years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) stroke, transient ischemic attack (TIA), or heart or blood vessel surgery; (2) dementia, Alzheimer's disease, or ALS (amyotrophic lateral sclerosis); (3) diabetes; (4) cancer (not including basal cell skin cancer); (5) AIDS (Acquired Immunodeficiency Syndrome), infection with HIV (Human Immunodeficiency Virus), or other immune system disorder; (6) mental or nervous system disorder for which inpatient treatment or confinement in an institution was recommended or completed; (7) alcohol or drug abuse, or has treatment been recommended? ( ) Yes (X) No

E. Physician's Name (Please Print) _____ Phone Number _____

Physician's Address _____

2. Beneficiary Designation (will be divided equally unless noted otherwise)

Beneficiary Name (Please Print)	Relationship to You	% Share
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!	!!!!!!!!!!!!!!!!!!!!	####
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!	!!!!!!!!!!!!!!!!!!!!	####

3. Is this insurance intended to replace or change any existing life insurance or annuity plan? ( ) Yes (X) No

Name of Insurance Company Plan of Insurance Amount of Insurance

I have read the questions and my answers are true to the best of my knowledge and belief. I understand that this application shall form a part of any policy issued and that, within the contestable period, a false statement or answer can be used to contest the policy as of its effective date or to deny a claim. **I understand and agree that no life insurance is in effect as a result of this application unless this application is approved by the Company, a policy is issued during my lifetime and my continued insurability, according to medical information provided in this application, and the premium has been paid.** The policy will be effective on the Policy Date shown on the Policy Schedule.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or any other organization, institution or person, that has any records or knowledge of me or my health, to give to Colonial Penn Life Insurance Company and its underwriters or reinsurers any such information. I understand such information will be used to determine my eligibility for this insurance. A reproduction of this authorization shall be as valid as the original. The authorization will be valid for a period of 24 months from the date signed. I understand that upon request, I or an authorized representative have a right to receive a copy of this authorization. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. I have received and read the Notice to Applicant. I have read the fraud notice applicable to my state, if any, on the reverse side of this form.

Signature of Proposed Insured _____ **Date** _____
(your legal signature - do not print)

12-82-055(REV)

########

LL29543-1112

GENERAL

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and a denial of insurance benefits.

MARYLAND

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

WASHINGTON

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Instructions:

1. Please review and complete this form. If you make changes, please make them on both copies and initial your changes. Be sure to sign and date both copies and return one copy to us. Attach the other copy to your Policy.
2. Make a check or money order payable to Colonial Penn Life for the amount shown on your premium notice. If you are paying by credit card, we will automatically charge your premium to your credit card.

Questions? Call us Toll-Free ############# for Assistance

APPLICATION For ####################

Colonial Penn Life Insurance Company, Philadelphia, PA 19181

Source Code: ##########
##########
########

Proposed Insured: ##############################

Date of Birth: ######## **Age:** ## **Sex:** ######

Area Code/Phone: ############# **Area Code/Phone:**

Proposed Owner: ############################## **Relationship:** ###################

Owner Address: ############################## ##

City, State, Zip: !! **E-Mail Address:** !!

Area Code/Phone: ############# **Area Code/Phone:**

Amount of Life Insurance: ###########

I wish to pay: ############# **Premium payment enclosed:** #########

1. **Statement of Health -- Answer each of the following questions "Yes" or "No." If "Yes"** ***CIRCLE*** **the condition(s) which apply.**

A. Are you currently: (1) using assistance from another person to perform your daily activities such as dressing, eating or walking; (2) using a walker, wheelchair or motorized mobility device; (3) using supplemental oxygen; (4) confined to a hospital, assisted care or nursing facility, or correctional institution? ( )Yes (X)No

B. Have you been advised to have in-patient surgery which has not yet been performed? ( )Yes (X)No

C. In the past three years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis; (2) chronic liver disease (including chronic hepatitis), cirrhosis of the liver; (3) chronic kidney disease (not including kidney stones); (4) heart attack (myocardial infarction), cardiac arrhythmia, or congestive heart failure; (5) thrombosis or embolism (blood clots)? ( )Yes (X)No

D. In the past five years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) stroke, transient ischemic attack (TIA), or heart or blood vessel surgery; (2) dementia, Alzheimer's disease, or ALS (amyotrophic lateral sclerosis); (3) diabetes; (4) cancer (not including basal cell skin cancer); (5) AIDS (Acquired Immunodeficiency Syndrome), infection with HIV (Human Immunodeficiency Virus), or other immune system disorder; (6) mental or nervous system disorder for which inpatient treatment or confinement in an institution was recommended or completed; (7) alcohol or drug abuse, or has treatment been recommended? ( )Yes (X)No

E. Physician's Name (Please Print) ____________ Phone Number ____________

Physician's Address ____________

2. **Beneficiary Designation (will be divided equally unless noted otherwise)**

Beneficiary Name (Please Print)	Relationship to You	% Share	Beneficiary Name (Please Print)	Relationship to You	% Share
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!	!!!!!!!!!!!!!!!!!!!!	####	!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!	!!!!!!!!!!!!!!!!!!!!	####

3. Is this insurance intended to replace or change any existing life insurance or annuity plan? ( )Yes (X)No

Name of Insurance Company ____ Plan of Insurance ____ Amount of Insurance ____

I have read the questions and my answers are true to the best of my knowledge and belief. I understand that this application shall form a part of any policy issued and that, within the contestable period, a false statement or answer can be used to contest the policy as of its effective date or to deny a claim. **I understand and agree that no life insurance is in effect as a result of this application unless this application is approved by the Company, a policy is issued during my lifetime and my continued insurability, according to medical information provided in this application, and the premium has been paid.** The policy will be effective on the Policy Date shown on the Policy Schedule.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or any other organization, institution or person, that has any records or knowledge of me or my health, to give to Colonial Penn Life Insurance Company and its underwriters or reinsurers any such information. I understand such information will be used to determine my eligibility for this insurance. A reproduction of this authorization shall be as valid as the original. The authorization will be valid for a period of 24 months from the date signed. I understand that upon request, I or an authorized representative have a right to receive a copy of this authorization. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. I have received and read the Notice to Applicant. I have read the fraud notice applicable to my state, if any, on the reverse side of this form.

Signature of Proposed Insured ____________ **Date** ____________
(your legal signature - do not print)

Signature of Proposed Owner ____________ **Date** ____________
(if other than Insured) *(your legal signature - do not print)*

12-82-056(REV)

########

LL29563-1112

GENERAL

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and a denial of insurance benefits.

MARYLAND

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

WASHINGTON

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Instructions:

1. Please review and complete this form. If you make changes, please make them on both copies and initial your changes. Be sure to sign and date both copies and return one copy to us. Attach the other copy to your Policy.
2. Make a check or money order payable to Colonial Penn Life for the amount shown on your premium notice. If you are paying by credit card, we will automatically charge your premium to your credit card.

Questions? Call us Toll-Free ############## for Assistance

APPLICATION For ####################
Colonial Penn Life Insurance Company, Philadelphia, PA 19181

Source Code: ##########
##########
########

Proposed Insured ############################## ## ## ##	**E-Mail Address:** !! **Date of Birth:** ######## **Age:** ## **Sex:** ######
Area Code/Phone: ##############	**Area Code/Phone:**
Amount of Life Insurance: ########### **I wish to pay:** ############	**Amount of Accidental Death Protection:** ########### **Amount of premium payment enclosed:** #########

1. Statement of Health -- Answer each of the following questions "Yes" or "No." If "Yes" *CIRCLE* the condition(s) which apply.

A. Are you currently: (1) using assistance from another person to perform your daily activities such as dressing, eating or walking; (2) using a walker, wheelchair or motorized mobility device; (3) using supplemental oxygen; (4) confined to a hospital, assisted care or nursing facility, or correctional institution? ( ) Yes (X) No

B. Have you been advised to have in-patient surgery which has not yet been performed? ( ) Yes (X) No

C. In the past three years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis; (2) chronic liver disease (including chronic hepatitis), cirrhosis of the liver; (3) chronic kidney disease (not including kidney stones); (4) heart attack (myocardial infarction), cardiac arrhythmia, or congestive heart failure; (5) thrombosis or embolism (blood clots)? ( ) Yes (X) No

D. In the past five years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) stroke, transient ischemic attack (TIA), or heart or blood vessel surgery; (2) dementia, Alzheimer's disease, or ALS (amyotrophic lateral sclerosis); (3) diabetes; (4) cancer (not including basal cell skin cancer); (5) AIDS (Acquired Immunodeficiency Syndrome), infection with HIV (Human Immunodeficiency Virus), or other immune system disorder; (6) mental or nervous system disorder for which inpatient treatment or confinement in an institution was recommended or completed; (7) alcohol or drug abuse, or has treatment been recommended? ( ) Yes (X) No

E. Physician's Name (Please Print) _____ Phone Number _____

Physician's Address _____

2. Beneficiary Designation (will be divided equally unless noted otherwise)

Beneficiary Name (Please Print)	Relationship to You	% Share
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!	!!!!!!!!!!!!!!!!!!!!	####
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!	!!!!!!!!!!!!!!!!!!!!	####

3. Is this insurance intended to replace or change any existing life insurance or annuity plan? ( ) Yes (X) No

Name of Insurance Company	Plan of Insurance	Amount of Insurance

I have read the questions and my answers are true to the best of my knowledge and belief. I understand that this application shall form a part of any policy issued and that, within the contestable period, a false statement or answer can be used to contest the policy as of its effective date or to deny a claim. **I understand and agree that no life insurance is in effect as a result of this application unless this application is approved by the Company and a policy is issued during my lifetime and my continued insurability, according to medical information provided in this application. In addition, no life insurance or, if elected, additional accidental death protection, is in effect unless the appropriate premium has been paid.** The life insurance benefit will be effective on the Policy Date shown on the Policy Schedule. If I elected additional accidental death protection, the accidental death benefit will be effective on the Rider Effective Date shown on the rider attached to the policy.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or any other organization, institution or person, that has any records or knowledge of me or my health, to give to Colonial Penn Life Insurance Company and its underwriters or reinsurers any such information. I understand such information will be used to determine my eligibility for this insurance. A reproduction of this authorization shall be as valid as the original. The authorization will be valid for a period of 24 months from the date signed. I understand that upon request, I or an authorized representative have a right to receive a copy of this authorization. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. I have received and read the Notice to Applicant. I have read the fraud notice applicable to my state, if any, on the reverse side of this form.

Signature of Proposed Insured _____ **Date** _____
(your legal signature - do not print)

12-82-057(REV)

########

LL29553-1112

GENERAL

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines and a denial of insurance benefits.

MARYLAND

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW JERSEY

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

WASHINGTON

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Instructions:

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2. Make a check or money order payable to Colonial Penn Life for the amount shown on your premium notice. If you are paying by credit card, we will automatically charge your premium to your credit card.

Questions? Call us Toll-Free ############# for Assistance

APPLICATION For

Colonial Penn Life Insurance Company, Philadelphia, PA 19181

Source Code: ########## ########## ########

Proposed Insured: ##############################
Date of Birth: ######## **Age:** ## **Sex:** ######
Area Code/Phone: ############# **Area Code/Phone:**

Proposed Owner: ############################## **Relationship:** ####################
Owner Address: ############################## ##
City, State, Zip: !!! **E-Mail Address:** !!
Area Code/Phone: ############# **Area Code/Phone:**

Amount of Life Insurance: ########### **Amount of Accidental Death Protection:** ##########
I wish to pay: ############# **Premium payment enclosed:** #########

1. Statement of Health -- Answer each of the following questions "Yes" or "No." If "Yes" *CIRCLE* the condition(s) which apply.

A. Are you currently: (1) using assistance from another person to perform your daily activities such as dressing, eating or walking; (2) using a walker, wheelchair or motorized mobility device; (3) using supplemental oxygen; (4) confined to a hospital, assisted care or nursing facility, or correctional institution? ( )Yes (X)No

B. Have you been advised to have in-patient surgery which has not yet been performed? ( )Yes (X)No

C. In the past three years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) chronic obstructive pulmonary disease (COPD), emphysema or chronic bronchitis; (2) chronic liver disease (including chronic hepatitis), cirrhosis of the liver; (3) chronic kidney disease (not including kidney stones); (4) heart attack (myocardial infarction), cardiac arrhythmia, or congestive heart failure; (5) thrombosis or embolism (blood clots)? ( )Yes (X)No

D. In the past five years, have you had, been diagnosed by a member of the medical profession with, or received treatment for (1) stroke, transient ischemic attack (TIA), or heart or blood vessel surgery; (2) dementia, Alzheimer's disease, or ALS (amyotrophic lateral sclerosis); (3) diabetes; (4) cancer (not including basal cell skin cancer); (5) AIDS (Acquired Immunodeficiency Syndrome), infection with HIV (Human Immunodeficiency Virus), or other immune system disorder; (6) mental or nervous system disorder for which inpatient treatment or confinement in an institution was recommended or completed; (7) alcohol or drug abuse, or has treatment been recommended? ( )Yes (X)No

E. Physician's Name (Please Print) ____________ Phone Number ____________
Physician's Address ____________

2. Beneficiary Designation (will be divided equally unless noted otherwise)

Beneficiary Name (Please Print)	Relationship to You	% Share	Beneficiary Name (Please Print)	Relationship to You	% Share
!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!	!!!!!!!!!!!!!!!!!!!!	####	!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!	!!!!!!!!!!!!!!!!!!!!	####

3. Is this insurance intended to replace or change any existing life insurance or annuity plan? ( )Yes (X)No

Name of Insurance Company	Plan of Insurance	Amount of Insurance

I have read the questions and my answers are true to the best of my knowledge and belief. I understand that this application shall form a part of any policy issued and that, within the contestable period, a false statement or answer can be used to contest the policy as of its effective date or to deny a claim. **I understand and agree that no life insurance is in effect as a result of this application unless this application is approved by the Company and a policy is issued during my lifetime and my continued insurability, according to medical information provided in this application. In addition, no life insurance or, if elected, additional accidental death protection, is in effect unless the appropriate premium has been paid.** The life insurance benefit will be effective on the Policy Date shown on the Policy Schedule. If I elected additional accidental death protection, the accidental death benefit will be effective on the Rider Effective Date shown on the rider attached to the policy.

I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or MIB, Inc., or any other organization, institution or person, that has any records or knowledge of me or my health, to give to Colonial Penn Life Insurance Company and its underwriters or reinsurers any such information. I understand such information will be used to determine my eligibility for this insurance. A reproduction of this authorization shall be as valid as the original. The authorization will be valid for a period of 24 months from the date signed. I understand that upon request, I or an authorized representative have a right to receive a copy of this authorization. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB. I have received and read the Notice to Applicant. I have read the fraud notice applicable to my state, if any, on the reverse side of this form.

Signature of Proposed Insured ____________ **Date** ____________
(your legal signature - do not print)

Signature of Proposed Owner ____________ **Date** ____________
(if other than Insured) *(your legal signature - do not print)*

12-82-058(REV)

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LL29572-1112

GENERAL

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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SERFF Tracking #:	*BNLC-128694484*	***State Tracking #:***	***Company Tracking #:*** *12-82-049(F)(REV)*

State:	*Arkansas*	***Filing Company:***	*Colonial Penn Life Insurance Company*
TOI/Sub-TOI:	*L07I Individual Life - Whole/L07I.111 Single Premium - Single Life*		
Product Name:	*Individual Life Insurance*		
Project Name/Number:	*/*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
ar recert.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Application		
Comments:	See supporting doc and filing description		

		Item Status:	**Status Date:**
Satisfied - Item:	Officers Certification		
Comments:			
Attachment(s):			
Officer's Cert.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Copy of Approval		
Comments:			
Attachment(s):			
ar copy of approval.pdf			

Colonial Penn Life Insurance Company • 399 Market Street • Philadelphia, Pennsylvania 19181

ARKANSAS
READABILITY CERTIFICATION

This is to certify that the attached applications, Form Nos. 12-82-049(F)(REV), 12-82-050(F)(REV), 12-82-055(REV), 12-82-056(REV), 12-82-057(REV) and 12-82-058(REV) have achieved a Flesch Reading Ease Score of 57.2 and comply with the requirements of ACA 23-80-206.

Signature of Officer

Betty Hewes-Eddinger
Name of Officer

Assistant Secretary
Title

9/20/12
Date

Colonial Penn Life Insurance Company • 399 Market Street • Philadelphia, Pennsylvania 19181

OFFICER'S CERTIFICATION

I, Betty Hewes-Eddinger, Assistant Secretary of Colonial Penn Life Insurance Company, do hereby certify that the only change to the previously approved forms contained in this filing is the addition of the MIB language at the end of the second paragraph of the authorization section. No other changes have been made to the forms.

Betty Hewes-Eddinger

SERFF Tracking Number:	*BNLC-126676280*	*State:*	*Arkansas*
Filing Company:	*Colonial Penn Life Insurance Company*	*State Tracking Number:*	*46598*
Company Tracking Number:			
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life*
Product Name:	*Individual Term and Whole Life Applications*		
Project Name/Number:	*SI Applications/12-82-049(F)*		

Filing at a Glance

Company: Colonial Penn Life Insurance Company

Product Name: Individual Term and Whole Life Applications	SERFF Tr Num: BNLC-126676280	State: Arkansas
TOI: L04I Individual Life - Term	SERFF Status: Closed-Approved-Closed	State Tr Num: 46598
Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status: Author: Karen Schussler Date Submitted: 08/25/2010	Reviewer(s): Linda Bird Disposition Date: 08/26/2010 Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

General Information

Project Name: SI Applications
Project Number: 12-82-049(F)
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 08/26/2010
Company Status Changed:
Deemer Date:
Submitted By: Karen Schussler
Filing Description:
12-82-049(F) Application for Life Insurance
12-82-050(F) Application for Life Insurance with Accidental Death Rider
12-82-055 Application for Life Insurance
12-82-056 Application for Life Insurance
12-82-057 Application for Life Insurance with Accidental Death Rider
12-82-058 Application for Life Insurance with Accidental Death Rider

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Group Market Size:
Group Market Type:
Explanation for Other Group Market Type:
State Status Changed: 08/26/2010
Created By: Karen Schussler
Corresponding Filing Tracking Number: